MIDWIFERY:

A DISCUSSION PAPER

Prepared for

The Manitoba Advisory Council on the Status of Women

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TABLE OF CONTENTS

	PAGE
INTRODUCTION	1
BACKGROUND	4
I. MIDWIFERY: POTENTIAL ROLE IN THE HEALTH CARE SYSTEM	8
II. MIDWIFERY: IMPLEMENTATION ISSUES	29
III. PRELIMINARY RESPONSES OF HEALTH CARE ORGANIZATIONS	41
CONSULTATION PROCESS	49
APPENDIX: QUESTIONS FOR DISCUSSION	51

INTRODUCTION

THE MANITOBA ADVISORY COUNCIL ON THE STATUS OF WOMEN

The Manitoba Advisory Council on the Status of Women is a fourteen member council appointed by the Government of Manitoba.

The mandate of the Advisory Council is to advise the Manitoba Government on matters relating to the status of women, with the objective of bringing about equality of opportunity and treatment for women and men in the province.

In fulfilling its mandate, the Advisory Council consults regularly with women and women's organizations across Manitoba.

THE ADVISORY COUNCIL AND MIDWIFERY

Concerns about maternity care services in Manitoba were recently brought to the attention of the Advisory Council through one of its members, Beverley Cann. The Advisory Council agreed to pursue these concerns and Ms. Cann, a registered nurse, was asked to chair a sub-committee with a mandate to develop a discussion paper on midwifery. Sub-committee members included Kris Robinson, a nurse-midwife trained in Britain; Norma Buchan, a consultant with the Manitoba Maternal and Child Health Directorate; Darlene Birch, a practicing lay midwife; Hanna Fonseca, with a background in anthropology and public health education; and Nancy McKeen, an active member of the Manitoba Association of Child and Family Education (M.A.C.F.E.).

Through the volunteer efforts of the sub-committee, a discussion paper was drafted for the Advisory Council's approval. Council adopted the position put forward in the paper which supports the legalization of midwifery and its incorporation into Manitoba's health care system.

THE ADVISORY COUNCIL'S DISCUSSION PAPER

Part I of the discussion paper begins with an overview of current maternity care. This is followed by a definition of midwifery, its history and current status and an exploration of the potential role of midwifery in the Canadian health care system.

In Part II, a number of issues are identified regarding the implementation of midwifery services. Some of the more important of these include the legalization and regulation of midwifery practice and the provision of midwifery education programs. Questions for discussion are also raised.

Part III of the paper contains a summary of the responses to a questionnaire recently distributed by Council to a number of provincial organizations representing both consumers of health care services and health care providers. By including these responses, Council is able to convey to the public the views of these groups regarding the legalization and implementation of midwifery in Manitoba.

THE ADVISORY COUNCIL WANTS YOUR PARTICIPATION

The purpose of this paper is twofold: to stimulate public discussion on the issue of midwifery and its potential role within Manitoba's health care system and to enable the Advisory Council to assess both the level of support for Council's position and the direction it should take in advising the Manitoba Government.

The Advisory Council intends to distribute the paper to a variety of individuals and groups across the province and to solicit from them comments and suggestions which will then be incorporated by Council into formal recommendations to the Manitoba Government.

BACKGROUND

WHY MIDWIFERY?

Over the past several years, more and more Canadian women have become disenchanted with modern maternity care which often alienates them from the experience of childbirth, treating this experience not as a natural process but as an illness requiring sophisticated technological intervention.

Dissatisfied with current medical practice, many individuals and organizations are now calling for the incorporation of midwifery services into the health care system. Midwifery practice emphasizes the normal aspects of childbirth; it fosters the active participation of women in pregnancy and the birthing process and offers continuity of care from prenatal through to post-partum stages.

WHY MIDWIFERY NOW?

The issue of midwifery has recently received a good deal of attention, both in professional literature and in the public media. This has been, in large measure, a result of the efforts of several provincial and national organizations consisting of health care consumers, midwives and health care professionals. These organizations are lobbying for improved services to childbearing women and their families.

In 1979, the Social Planning Council of Winnipeg established the Community Task Force on Maternal and Child Health. The Task Force included in its agenda a review of laws governing midwifery practice in Canada and summarized the positions of several interested organizations regarding the liberalization of midwifery laws. Although the Task Force report, released in 1981, made no recommendations

regarding midwifery services in Manitoba, its tone clearly favoured the utilization of trained midwives in Canadian obstetric care.[1]

In February 1984, the Honourable Larry Desjardins, Minister of Health, established the Health Services Review Committee to study Manitoba's health delivery network and to make recommendations to the provincial government regarding future directions. The Committee published a three volume report in November 1985. The Subcommittee on Obstetrics proposed a number of progressive solutions to problems associated with the current maternity care system, many of which incoporated the notions of community-based out-patient care, greater utilization of nursing skills and increased emphasis on continuity of care. This sub-committee also suggested the establishment of an ad hoc task force to study, and to make recommendations on, the expansion of the role of the nurse in reproductive health care, with specific reference to nurse midwifery.[2]

More recently, the Ontario Minister of Health, the Honourable Murray Elston, announced his government's intention to establish midwifery as a recognized part of the Ontario health care system. This action was prompted, in part, by the July 1985 verdict of a coroner's jury which investigated the death of an infant following a home delivery attended by two midwives. The jury recommended the legalization of midwifery under the Ontario Health Disciplines Act.[3] As part of a Health Professions Legislation Review, Mr. Elston intends to address the following issues: qualification for midwifery practice, the relationship between midwives and physicians, settings for the provision of midwifery services, and recommended education programs.[4]

ENDNOTES

1. Community Task Force on Maternal and Child Health, "Midwifery Law", in Childbearing Families and the Law, A Law Review Series, Social Planning Council of Winnipeg, Winnipeg, March, 1981

2. "Report of the Sub-Committee on Obstetrics", Report of the Health Services Review Committee, Volume III: Sub-Committees' Reports, November, 1985, 33

3. Verdict of Coroner's Jury serving on the inquest into the death of Daniel McLaughlin-Harris, July 17, 1985

4. Statement by the Honourable Murray Elston, Minister of Health, Re: Midwifery, Queen's Park, Ontario, January 23, 1986

I. MIDWIFERY: POTENTIAL ROLE IN THE HEALTH CARE SYSTEM

CURRENT MATERNITY CARE: AN OVERVIEW

i) Childbirth as Pathology

Pregnancy has been viewed by physicians as a disease from the time that childbirth moved from the home to the hospital. As Dr. Murray Enkin, Associate Professor of Obstetrics at McMaster University observes, the dominant view within modern obstetrics has been that pregnancy should be "... managed on the assumption that it is better to treat a well person as sick, than a sick person as well; that no pregnancy can be considered normal except in retrospect".[1]

The expertise of the modern physician and obstetrician is in the area of pathology. This is evident even in medical training. For instance, one study of a hospital maternity unit found that:

> (i)n cases where no complications were ... present ... an atmosphere of general apprehension pervaded the team -- particularly during delivery. In cases with possible imminent complications, the members of the team seemed considerably more at ease; tension lessened and they appeared able to set about their tasks in a more relaxed and workmanlike manner. To the students, the latter situations were those in which they were actually 'learning something'.[2]

It appears that medical students are encouraged to focus on the management of abnormalities in childbirth, rather than on the provision of support and assistance.

ii) Childbirth and Technological Intervention

The view of childbirth as pathology has led to an increase in the development and use of sophisticated technology in obstetrics. In recent years, electronic

monitoring devices, a variety of drugs, and medical procedures such as artificial induction of labour and delivery by cesarean section, have been developed to protect birthing women and their newborns.

While the use of technology is essential in a small number of cases, such interventions have increasingly been employed by physicians as preventive measures in cases of low risk pregnancy and childbirth. Evidence suggests that the use of technological intervention in low risk cases is at best questionable and, in many instances, may well be harmful to mother and child.[3] As Muriel Sugarman notes, unnecessary intervention in childbirth may "... interfere with the process of normal labor, birth and post partum family relationships, and produce side effects which can cause illness or complications".[4]

iii) Fragmentation of Care

Fragmentation of care is one of the most significant weaknesses of the current maternity care system.

Maternity care in Canada tends to focus on labour and the delivery of babies and not on the pre-natal and post partum phases. During the prenatal period, most physicians are unable to provide adequate hours for preventive care. As Barbara Katz Rothman explains:

> (t)he pregnant woman sees the obstetrician each month during the first two trimesters, twice a month for the seventh and eighth months, and weekly for the last month. These visits typically take ten to fifteen minutes or less.[5]

Katz Rothman goes on to emphasize that "(t)ime ... is of the essence as the doctor moves from one examining room to the next".[6]

It appears that time is also limited in respect of post-partum care. With the exception of a pre-scheduled physical check-up approximately six weeks after childbirth, most new mothers and their babies are quickly turned out into the community with little or no formal supports.

Current maternity care is also fragmented in that during the course of her pregnancy and beyond, a birthing woman must contend with what Eleanor Barrington refers to as a "parade of new faces".[7] A birthing woman may be cared for by her family doctor, several labour and delivery nurses, post-partum nurses and a public health nurse. In many cases, the services of an obstetrician, or an obstetrics resident, an anaesthetist and a pediatrician may also be required.

Fragmentation of care is manifest not only by a lack of adequacy and continuity in perinatal care but also by a tendency on the part of physicians to emphasize only the physiological aspects of pregnancy, childbirth and early parenting. During the prenatal period, for instance, individualized care and attention to the full range of a birthing woman's needs are crucial in keeping the low risk pregnancy in that category. But, as Barrington notes, because of the time constraints that characterize the current maternity care system, " ... it is virtually impossible for an obstetrician to question, assess and direct a mother's diet, exercise, psychological state, family situation, and all the other indicators of potential pregnancy and birth complications".[8]

MIDWIFERY DEFINED

A midwife is someone who assists women in giving birth. Midwives are recognized as experts in normal and natural birth procedures; they take responsibility for supervising pregnancies, and educating as well as advising parents, from prenatal through to post-partum stages.

The International Confederation of Midwives and the International Federation of Obstetrics and Gynecology have defined a midwife as:

> ... a person who ... has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and legally licensed to practice midwifery. She/he must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period, to conduct deliveries on his/her own responsibility and to care for the newborn. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help ... she may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.[9]

Very often, members of the public assume that midwifery and home birth are synonymous. As is evident from the above definition, the association of midwifery exclusively with home birth under-represents its scope and breadth.

HISTORY OF MIDWIFERY

Although the practice of midwifery dates back several centuries, it was gradually eroded in Canada during the latter part of the 19th century by the proliferation of male doctors trained in obstetrics.[10]

Until 1850, lay healers and midwives practiced in all parts of Canada. During the 1850's, however, the number of physicians trying to make a living in Toronto and Montreal began to increase. As a result of a number of factors including the pressure of competition, doctors began to view the birthing process as an area appropriate for specialized medical practice. In Nova Scotia, which also had a relatively large physician population, doctors began to attend births in the 1860's. Elsewhere in Canada, this encroachment on the territory of midwives was delayed for a decade or two.

In 1865, a statute of the Province of Canada placed midwifery under the jurisdiction of licensed medical practitioners. This meant that midwives were subject to control by the medical profession. This statute, however, did not immediately reflect actual practice and midwives continued for several years to practice independently without direct supervision from physicians.

Although the trend towards physician dominated birth began in the 1860's, the place of birth continued to be the home rather than the hospital. Crowded, dirty hospitals provided ripe conditions for the spread of infections. Usually only destitute women gave birth in hospitals.

It was not until the 1890's that there was a systematic effort to improve conditions in lying-in hospitals in Ontario and Quebec. At the same time, the expansion of

medical colleges created a need for more obstetrical patients. As a result, there was increased pressure to move birth from the home to the hospital.

The push towards hospital birth helped to hasten the demise of the practice of midwifery in Canada. Nurses, as well as doctors, resisted the presence of midwives in hospitals. Resistance by nurses reflected the uneasy and unequal alliance that this emerging profession had made with the medical profession in order to survive.

Isolated from one another in a vast country, with no access to education or to hospital privileges to attend births, Canadian midwives could not hope to continue to practice actively. The organization of the medical profession, legislation supporting medical ascendancy in health care, and the twentieth century trend towards hospital birth, all contributed to the near disappearance of Canadian midwifery by 1950.

RE-EMERGENCE OF MIDWIFERY

The midwifery movement in Canada began to take root once again during the late 1960's, after two decades during which childbirth was increasingly viewed as a crisis requiring medical intervention.

During the 1940's and the 1950's, women giving birth became increasingly disenchanted with what had become a highly technical, physician-dominated hospital delivery system. Richard Wertz and Dorothy Wertz describe women's experience of childbirth during this period:

> (h)ospital delivery had become for many a time of alienation -- from the body, from family and friends, from the community, and even from life itself. The safe efficiencies had become a kind of industrial production far removed from the comforts of social childbirth or the sympathies of the proverbial doctor-patient relation. A woman was powerless in the experience of birth and unable to find meaning in it, for her participation in it and even her consciousness of it were minimal.[11]

During the 1960's, social change movements, such as the women's movement and consumer health movements, contributed to an increase in public demand for greater control over health care services, including maternity care. An increasing number of expectant women began to regard themselves as consumers of maternity services, demanding that they play a more active role in the management of pregnancy and childbirth. It was during this period that the practice of midwifery in Canada was revived.

CURRENT STATUS OF MIDWIFERY

Of the two hundred and ten member countries of the World Health Organization, only Canada and seven developing countries do not provide comprehensive midwifery care during normal childbirth. Canada shares this anomalous status with Burundi, Columbia, the Dominican Republic, El Salvador, New Hebrides, Panama and Venezuela.

Laws governing the practice of midwifery in Canada differ from province to province. At best, the current legal status of midwifery in any province is uncertain.

In Manitoba, like most other jurisdictions, legislation relevant to the practice of midwifery is contained in the Medical Act.[12] Provisions in this Act include midwifery as a form of practicing medicine and restrict this practice to licensed physicians. Although these provisions have not yet been challenged in the courts, it is likely, as observed by Barrington, that midwifery in Manitoba is illegal.[13]

In spite of restrictive legislation governing the practice of midwifery, midwives do deliver babies in Canada. It is well known that, until recently, the Medical Services Branch of Health and Welfare Canada actively recruited trained midwives from the United Kingdom and other countries to practice in remote northern outposts and nursing stations.

Although nurses are not allowed to deliver babies, many hospital obstetrical wards gratefully utilize the skills of those who have midwifery training. The Manitoba Association of Registered Nurses reports that currently there are 34 nurse midwives on its roster.

Most provinces have an active contingent of midwives who privately provide their services to women in conjunction

with available health services and/or to women choosing home birth.

ALTERNATE BIRTH SETTINGS

Growing numbers of couples, having become dissatisfied with institutionalized birth, are now seeking not only the services of midwives but also increased options in respect of birth settings.

In response to consumer pressure, many hospitals have changed policies and practices to reflect a more humanized approach to childbirth. One such change has been the development of alternate birthing rooms located within more traditional hospital labour and delivery wards.

The alternate birthing room is designed to allow the low risk birthing woman the opportunity to labour and deliver in home like surroundings. Through lighting, furnishings and privacy, birthing rooms are designed to reflect the warmth, freedom and security of home while providing immediate access to emergency back-up should it be required.

Most Winnipeg hospitals are now equipped with alternate birthing rooms. These facilities, however, are in high demand and many women are disappointed to find the rooms occupied when they arrive at the hospital.

Outside of Winnipeg, only one hospital, the Brandon General, is equipped with an alternate birthing room.

A small percentage of women choose to deliver their babies at home. Reasons for choosing home birth vary. Some women cite preference for what they perceive to be an intimate, family-centred approach to an event of high emotional and spiritual significance. Others perceive home birth as allowing for increased safety and personal control in the birthing process.

MIDWIFERY AND THE MATERNITY CARE SYSTEM

i) An Expert in Normal Childbirth

While the expertise of the physician lies in the area of pathology, just the opposite is true for the midwife. Indeed, as Barrington notes: "(b)y international recognition, the midwife is the specialist in normal birth. Her training focuses on the healthy process of parturition, and how to facilitate this process without upsetting nature's intricate balance."[14]

ii) Minimization of Technological Intervention

Although a completely natural birth is not always possible or preferred by a woman, midwives strive to limit unnecessary technological intervention. Midwives believe that giving birth is a natural process and they very carefully deliver babies in accordance with the intricate dictates of each woman's body.

A recent Canadian study of nurse midwives working with obstetricians in the context of a high risk centre showed that rates of interventions such as episiotomy, analgesia and anaesthesia were one-half of those in other obstetrical services.[15] Consumer satisfaction with the service was very high, the demand for this type of hospital based midwifery care exceeding the available services. The favourable outcome of hospital based midwifery care is further supported by American and European studies.[16]

In much of Europe, professionally trained midwives have for some decades been an integral part of the health care system. World Health Organization (WHO) statistics on neonatal death rates consistently show that Sweden, Holland, Finland, Japan and Denmark, which include midwives in their

health care, have better birth outcomes than either Canada or the United States.[17] Scandinavian countries generally have lower perinatal mortality rates than either the U.S. or Canada. Causal links between lower perinatal mortality rates and increased utilization of midwives must be made with caution, however, since many other social and economic factors also contribute to infant mortality and morbidity patterns.

iii) Continuity of Care: A Birthing Woman and Her Midwife

Continuity of care and individualized care are vital elements of the midwifery role. Midwifery practice includes a schedule of prenatal visits, patient education, labour attendance, delivery and post-partum care. The midwife individualizes her care to the particular needs and desires of each woman and her family.

The optimal development of the midwife-client relationship requires a frequent schedule of personal visits. The midwife continuum of care begins as early in pregnancy as possible. During prenatal visits the midwife assesses and gathers detailed information on the mother's physical and emotional health. The personal rapport she develops with the mother assists the midwife in detecting emotional upsets in pregnancy, birthing and the post-partum period, which may at any of these stages result in physical complications if not resolved.

With its emphasis on continuity of care, midwifery practice helps to minimize the depersonalization and fragmentation associated with the current maternity care system. By providing such care, midwives are able at an early stage to identify complications in pregnancy and childbirth, thereby maximizing the health and comfort of birthing women.

iv) Continuity of Care: A Community-Based Maternity Care System

As mentioned earlier, maternity care in Canada is now overwhelmingly hospital-based. Maternity care also tends to focus on labour and the delivery of babies, giving little attention to prenatal and post-partum phases.

A community-based system of maternity care which provides a continuum of care and incorporates the services of midwives has been proposed by many as an alternative to the current maternity care system. Sugarman, for instance, has proposed a system which would include a neighbourhood-based, coordinated network of prenatal clinics staffed primarily by midwives, nurse practitioners, community aides and advocates.[18] Such clinics would emphasize prevention, nutrition, ease of transportation, patient education and comprehensive screening for problems and risk factors, which would encompass social and psychological as well as physiological factors. Other services would include outreach by specially trained community workers, childbirth preparation, parenting preparation, nutrition supplementation and support for adolescents.

For normal births, Sugarman proposes a spectrum of alternatives. Low-risk women could choose home birth or birthing in out-of-hospital birth centres staffed by midwives and family practioners and supported by specialists and access to hospital facilities. Small community-based hospitals could provide care for women at moderate risk, women who choose hospital birth and those who would prefer out-of-hospital birth but require some hospital procedures.

For complicated, high-risk births, care in centralized perinatal centres is necessary. Such centres must be

equipped with sophisticated screening and diagnostic capabilities, specialized technological services, personnel and resources for perinatal complications. Psychological and social support for birthing families is essential and this would include follow-up into centralized perinatal centres by para-professionals and professionals such as community midwives.

Post-partum care plays an important role in Sugarman's community-based maternity care system. Follow-up services including long-term counselling and support for all birthing families would be provided by community workers and aides with back-up by visiting nurses, midwives and mental health professionals.

A community-based system of maternity care which includes the services of midwives would not only remove low and moderate risk birthing women from the highly technical and alienating hospital environment but would offer all birthing women and their newborns a continuity of care that is currently unavailable in Canada.

MIDWIFERY AND SPECIFIC MANITOBA COMMUNITIES

i) Northern Aboriginal Women

Aboriginal peoples of the North were the last cultures in Canada to retain a tradition of midwifery. The survival of northern aboriginal midwifery practice was due largely to geographic isolation, harsh climatic conditions and the distinctive lifestyles of aboriginal groups.

Aboriginal midwifery in the North was curtailed during the 1960's when the federal Medical Services Branch began to dispatch medical personnel into northern communities. Interestingly, while Medical Services was responsible for the decline of aboriginal midwifery in the North, it was itself the final bastion of midwifery in Canada: until 1970, Medical Services recruited foreign-trained nurse midwives to serve in nursing stations in isolated communities.

Up until recently, nurse midwives trained primarily in Britain and in Australia attended low-risk births in northern communities. A federal policy introduced in the early 1980's, however, has seriously diminished the influx into Canada of foreign-trained nurses, giving priority to the employment of Canadian nurses who usually have no training in midwifery. The introduction of this policy, together with a recent commitment by federal medical authorities to ensure the delivery of standardized, quality health care services throughout Canada, has resulted in the evacuation of pregnant northern women from their home communities to urban hospitals in the South.

In isolated northern communities, expectant women are routinely evacuated from their communities. Evacuation is the standard policy; variation only occurs in respect of the

point in a woman's pregnancy at which evacuation takes place.

Lorna Guse recently conducted an anthropological research project in which she interviewed 44 aboriginal women who were evacuated to Winnipeg to deliver their babies.[19] Although this was an exploratory study, and Guse cautions that the findings are not generalizable, the study pointed to obvious difficulties with the Medical Services Branch policy of maternal evacuation.

According to Guse, the problems associated with maternal evacuation include: feelings of loneliness, boredom and worry, and concern for the welfare of family members at home. Guse's findings have been substantiated by self-reports of northern women. One mother of ten, for instance, recently told a journalist that she was evacuated from her home community to deliver her youngest three children. She described these experiences as "heartbreaking" and went on to say:

> ... it just tore our family apart not to be able to stay together for a period of one month to two months, sometimes. There were times when my children actually cried for me and missed me. When I talked to them on the phone, they would just break down and cry and they would write me notes and letters and it was hard for me to stay stable, especially in my condition...[20]

Language and cultural barriers, as well as financial concerns, compound the problems associated with maternal evacuation. So too does the uncertainty of just how long the stay in the South may be.

Some northern women delay contact with the nursing station in an effort to prevent evacuation. This may be hazardous if complications arise.

Although maternal evacuation was introduced to meet the physical needs of childbearing northern women, it seems that little attention was given to the emotional impact and social disruption of the evacuation process.

A recent survey of Inuit women living in Eskimo Point showed that these women are overwhelmingly in favour of community-based childbirth services that would include the active involvement of Inuit midwives.[21]

The viewpoint expressed by women in Eskimo Point is reflected in a position recently taken by the Inuit Women's Association of Canada.[22] The Association has called for the staffing of northern nursing stations to include personnel experienced in midwifery. The Association wants Inuit midwives recognized and their skills utilized along with nurses attending births in northern communities.

The Indian Health Care Subcommittee of the Health Services Review Committee emphasized the need for Indian self-determination and specifically, the need for local control over health services.[23] It noted that only about 300 Indians in Canada are trained as nurses, while fewer than a dozen are physicians. The objective of local control highlights the need for trained nurses, physicians, health administrators and other health care workers drawn from the aboriginal population.

If aboriginal women were trained as midwives and delivered the babies of low risk women in their own communities, this could, in the short term, minimize the negative social, psychological and physical impact of maternal evacuation. In the long term, this training could contribute to the overall development of aboriginal control over health services.

ii) Rural Women

Very often, rural women must travel long distances to deliver babies and to receive quality prenatal care and education. As suggested earlier, the development of community-based facilities staffed by midwives would greatly reduce the psychological and social isolation currently experienced by these women.

iii) Immigrant Women

In most countries, midwifery is a normal and essential component of the childbirth process. Birthing without the care of midwives in highly technical hospital settings may be a bewildering and frightening experience for immigrant women.

Language barriers and different cultural perceptions of birth, health and illness must be considered in the provision of health care services. Culturally sensitive midwives, and midwives drawn from immigrant communities themselves, could provide the security of a relationship familiar to immigrant women while easing the culture shock of birthing in Canadian hospitals.

ENDNOTES

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17. Suzanne Arms, Immaculate Deception (Boston 1975) 43

18. Sugarman, "Improving the Outcome of Pregnancy", 112

19. Lorna Guse, "Maternal Evacuation: A Study of the Experiences of Northern Manitoba Native Women", University College Ethnology Papers, University of Manitoba, 1982

20. Bernadette Hardaker, C.B.C. Information Radio, November 1986

21. See John D. O'Neil, "Summary of Health Care and Birthing Study for the Eskimo Point Health Committee", Department of Social and Preventive Medicine, University of Manitoba, no date

22. News of the North, Fall, 1985

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II. MIDWIFERY:
IMPLEMENTATION ISSUES

IMPLEMENTATION ISSUES

The incorporation of midwifery into Manitoba's health care system will require the resolution of several major issues -- issues which are important to professionals providing health care services and ultimately, to the public they serve. These include: the legalization and regulation of midwifery, the education and training of midwives, the development of standards of midwifery practice, and the relationship between midwives and other health practitioners.

LEGALIZATION AND REGULATION

As mentioned earlier, Manitoba's Medical Act prohibits the practice of midwifery by all but licensed physicians.

If midwife-attended births are viewed as a desirable goal, statutory provision must be made to allow midwives to legally practice in Manitoba. Provision for the regulation of midwifery practice must also be established.

In considering the legalization and regulation of Canadian midwifery care, it may be helpful to review existing models in other countries.

Both certified nurse midwives and lay midwives currently practice in the United States. A certified nurse midwife is a registered nurse who has completed an additional educational program in the management of low risk pregnancy, childbirth and the care of normal newborns. Certified nurse midwives practice primarily in hospitals and alternate birthing centres.

American lay midwives are variously called lay midwives, independent midwives, granny midwives, empirical midwives or domiciliary midwives. Lay midwives attend births primarily in homes, with the support of a physician should an emergency require hospitalization. Some lay midwives practice in alternate birthing centres. To date, none have hospital privileges.

Both lay midwives and nurse midwives in the United States are represented by the Midwives Alliance of North America (MANA). This organization seeks to unify midwifery in the United States and Canada, to increase communication and cooperation among professional groups, to provide guidelines for the education of midwives and assurance of competency standards, and to promote research in midwifery and assure quality health care options for consumers.

In 1985, the American College of Obstetrics and Gynecology conducted a comprehensive study of the laws and regulations governing nurse and lay midwives in the fifty states.[1] With the exception of North Dakota, all states make statutory provision for the practice of certified nurse midwifery. The majority also prescribe that nurse midwives practice under the supervision of physicians.

Seventeen American states make statutory provision for the practice of lay midwifery. Nine states have revoked legal provision for lay midwifery practice, a few states specifically prohibit it and approximately twenty have no such statutory or regulatory provisions.

In Britain, midwives attend 70% of birthing women.[2] British midwives secured legal sanction for their profession under the Midwives Act of 1902 and were established as a Royal College in 1941. In September 1983, the Nurses, Midwives and Health Visitors Act abolished the specialist

body, the Central Midwives Board, which had for decades governed the practice of midwifery in Britain. The new body is comprised of both nurses and midwives whose task it is to regulate the two separate professions.

In the Netherlands, midwives are independent practitioners.

In Canada, the Interdisciplinary Midwifery Task Force Association of British Columbia recently drafted a model Midwifery Act.[3] The proposed Act deals with three main areas: defining a group of professionals who will comprise the regulating body; establishing committees which will develop standards for certification; and recommending training avenues for certification. The regulatory body proposed in the Act is to be made up of certified midwives and certified nurse-midwives. Its function would be to register and discipline its own members as well as to establish standards of midwifery practice.

Another proposal for the regulation of midwifery in Canada is contained in the recommendations of the Coronor's Inquest of July 1985, mentioned earlier. The Ontario jury recommended the following: that midwifery be legalized; that the Health Disciplines Act be amended to include the practice of midwifery; and that a body be established to govern the activities of midwives. It is recommended that this body be established in two phases. In the first phase, it is to be a specialty within the College of Nurses of Ontario and, after an organizational period, a new college of Midwives of Ontario is to be established. In the second phase, standards of training and of practice are to be established by the governing body.

Several questions arise regarding the legalization and regulation of midwifery practice in Manitoba. Some of the

more important of these include:

- should midwifery be incorporated into the Registered Nurses Act and hence, be licensed and governed by the Manitoba Association of Registered Nurses?

- should midwifery be governed by an autonomous, self-regulating professional body responsible for developing standards of practice, and for licensing and disciplining its members?

- what should be the legally prescribed nature of the relationship between midwives and physicians? Should it be collegial, consultative or should midwives be supervised by, and responsible to, physicians?

EDUCATION AND TRAINING

Up until very recently, formal midwifery education was not offered anywhere in Canada. Many women, however, view midwifery practice as a desirable career and thus, they have sought training elsewhere. Although no accurate count is available, there are presently a number of midwives in Manitoba, the majority of whom are foreign trained and certified.

Many nurses have also left the country to train as midwives. Once trained, they tend to return to Canada to seek employment within the health care system, most often as hospital labour and delivery nurses.

Some lay midwives receive training through apprenticeship with practicing midwives and home study programs. Others attend courses offered in the United States. Lay midwives practice in the community -- they may attend low risk deliveries in the home or they may act as labour coaches, accompanying birthing women to the hospital.

Since 1986, the University of Alberta has offered a two year Masters Degree Program in nurse-midwifery. This program, offering complete nurse-midwifery training, is the only such program in Canada.

In 1985, a midwifery school in British Columbia announced the completion of its first academic year and the graduation of midwives. The program is a direct entry program, accommodating students with various levels of skill, knowledge and experience. Graduates proceed to do preceptorships, apprenticing with qualified midwives in other countries.

Memorial University in Newfoundland offers components

of midwifery education. Students enrolled in this program, however, must complete their education and qualifying examinations outside of the country.

The current debate surrounding the education and training of midwives in Canada is closely tied to competing views of the legalization and regulation of midwifery practice. Essentially, two schools of thought predominate: there are those who believe that midwifery education should be offered only as an advanced specialty of nursing. This belief stems from the view that the legalization and regulation of midwifery most appropriately belongs within the sphere of the nursing profession. Others, however, favour a direct entry approach to midwifery education. It is argued that midwifery is a profession in its own right, and while certain nursing skills are required, it is not necessary for all midwives to be nurses.

Most American models of midwifery education are nursing based. In Finland, Sweden and Norway, only qualified nurses may take midwifery training. There are, however, internationally recognized programs which allow for direct entry.

In Denmark and France, nursing is not a prerequisite for midwifery training. In Germany and Belgium, midwifery is separate from nursing, although some nursing education is included in midwifery programs.

Both approaches to midwifery education are evident in the United Kingdom. In England and Wales, there is dual pathway, while in Scotland, nursing must precede midwifery training.

The current debate surrounding the education of midwives may hamper efforts to formally re-establish

midwifery in Canada. There is evidence, however, that nurse-midwives and lay midwives are moving to close the division. In November 1984, the Ontario Nurse-Midwives Association and the Ontario Association of Midwives amalgamated to form the Midwives Association of Ontario and in June 1985, the Western Canadian Nurse Midwives Association reported that one of its goals is to "work with the domiciliary midwives group to set up standards of practice and education of midwives".[4] Nurse midwives and lay midwives in British Columbia have also come together to form one organization.

Questions regarding the education and training of midwives include:

- what type of educational route should be required for an individual to gain professional status as a midwife? Should educational programs in midwifery be direct entry or should they be offered only as an advanced specialty of nursing?

- should previous experience and/or training in midwifery practice be recognized in educational programs? Should provision be made for grandmothering clauses, advanced standing admissions, reciprocity agreements with other provinces and countries and so on?

- how might educational programs in midwifery be made accessible to all women including northern, rural and immigrant women?

OTHER CHALLENGES

i) Health Care Professionals

The feelings and attitudes of health care professionals currently involved in the care of childbearing women and their families may present challenges to the incorporation of midwifery into Manitoba's health care system.

The nursing profession is now in the process of redefining and expanding its role in the health care field. Although many nurses support, indeed welcome, the growing interest in midwifery in Canada, their support is often conditional upon assurances that midwifery training will be offered only as an advanced speciality of nursing. This position becomes problematic if midwifery is to be a separate profession, which may or may not have nursing as a prerequisite.

Obstetrical nurses and midwives currently work side by side on equal footing in obstetrical units across Manitoba. Fearful of losing their status, obstetrical nurses may be disturbed by the prospect of midwifery as a formally recognized practice.

More and more family physicians are opting out of obstetrical care leaving a committed core who highly value their obstetrical practices. The suggestion that midwives assume more of the reponsibility for normal childbirth may be disturbing to this group as well, particularly for those family physicians who have never worked with midwives.

Canadian trained obstetricians who have not had the benefit of working with midwives may view the growing support for midwifery with concern, but few have outwardly voiced opposition. It would seem, however, that concerns

among this group revolve around home births attended by lay midwives and uncertainty about how the roles of the midwife and the physician are related. For obstetricians who are familiar with the work of midwives elsewhere in the world and, indeed, who have learned much of their normal obstetrics from midwives, concerns arise not out of uncertainty or fear, but rather with regard to the logistics of integrating midwives into the existing health care system.

The incorporation of midwifery into Manitoba's health care system will require a period of adjustment. It is anticipated, however, that strong, genuinely collegial relationships will develop among midwives, nurses, family physicians and obstetricians. A solid commitment to team work and to innovation by all professionals would produce a highly effective maternity care system.

ii) The Public

Many Canadians are not aware that midwifery services are an integral part of many health care delivery systems throughout the world. Public ignorance of the benefits of midwifery care may present significant barriers to an informed discussion of the issues. It is therefore essential that public education in this area be undertaken.

iii) Financial Considerations

Thus far, there are no Canadian-based research studies which document the economic advantages and disadvantages of midwifery. Although there will certainly be costs incurred through the formalization of midwifery, such as those associated with the establishment of educational programs and the infrastructure necessary for regulating the profession, remuneration schemes, liability insurance rates

and so on, it is likely that these costs will be outweighed by the benefits.

As mentioned ealier, because midwives strive to limit the use of unnecessary technological intervention, it is reasonable to assume that costs in this area will be reduced. It has been estimated that in Quebec, if the current rate of cesarean sections (18.8%) was reduced to that in Finland (11.9%), costs incurred by the provincial health care system would be reduced by approximately $19 million per year.[5]

If midwives are allowed to practice in community-based hospitals and clinics, many women will be able to deliver their babies either in their home communities, or very close by. The reduction in the number of expectant women having to travel from rural and northern communities to urban centres will likely also result in considerable savings.

In addition to the cost efficient aspects of midwifery, it is anticipated that there will be so-called "soft outcomes". That is, the incorporation of midwifery into Manitoba's health care system will likely increase both the health and the happiness of many childbearing families in Manitoba.

ENDNOTES

1. American College of Obstetrics and Gynecology, Fifty State Comprehensive Survey of Laws and Regulations Governing Both Nurse and Lay Midwives, 1985

2. M. Myles, Textbook for Midwives (New York 1981)

3. Community Task Force on Maternal and Child Health, "Midwifery Law", in Childbearing Families and the Law, A Law Review Series, Social Planning Council of Winnipeg, Winnipeg, March, 1981, 7

4. Western Canadian Nurse Midwives Association, Minutes, June, 1985

5. Christiane Brunelle, "La Naissance Selon Wagner", in La Vie En Rose, 42, January, 1987, 12

III. PRELIMINARY RESPONSES OF HEALTH CARE ORGANIZATIONS

COUNCIL QUESTIONNAIRE

To determine the level of support for midwifery in Manitoba, a number of organizations, representing both consumers of health care services and health care providers, were canvassed by the Advisory Council. Questionnaires were mailed to a total of twenty-two groups,[1] fourteen of which responded.[2] The results of the questionnaire are summarized in this section.

All respondents, with the exception of the College of Family Physicians of Canada, supported the legalization and implementation of midwifery services. Generally, the addition of a midwife to the maternity care team was viewed as an addition which would enhance the present health care system.

The College of Family Physicians of Canada opposed the introduction of legalized midwives. Members of this organization regard themselves as "... the only health care professionals who can provide continuity and comprehensiveness of care ... in every phase of (the) life cycle", including that of pregnancy and childbirth. They believe that in Canada the family physician provides "optimal obstetrical care".

Those respondents who most closely align themselves with consumer interests emphasized the need to expand options for birthing women by offering as wide a range as possible of birthing alternatives.[3] Midwifery is seen as one of these options.

Support was unanimous for a system of regulation and licensing or certification of midwives. There was disagreement, however, between those who believe that midwifery belongs within the sphere of the nursing

profession and those who maintain that it should be a profession in its own right.

Nursing and medical organizations[4] support the development of midwifery as a specialty of the profession of nursing.

Organizations[5] outside of the medical and nursing professions suppport the development of midwifery as an independent, self-regulating profession whose members would practice collaboratively with other health care professionals.

Several organizations[6] expressed support for midwifery without differentiating between nurse midwives and other professional midwives.

The Manitoba Association of Registered Nurses (M.A.R.N.), the regulatory body for registered nurses, stated that it believes that it should be given the authority to review the qualifications and competence of nurse midwives and, in consultation with nurses practicing midwifery, it should be responsible for the development of standards of practice. These standards, according to M.A.R.N., should reflect the level of performance and knowledge expected of the registered nurse midwife. M.A.R.N. further recommended that nurse midwives should practice within existing health care facilities, maintaining a collegial relationship with physicians.

The College of Physicians and Surgeons was more specific regarding its view of the relationship between midwives and physicians. The College stated that this relationship should include a component of supervision and back up by obstetricians.

The Manitoba Chapter of the Nurses Association of the American College of Obstetricians and Gynecologists (N.A.A.C.O.G.), and the Manitoba College of Physicians and Surgeons, suggested that standards of midwifery practice be developed in an interdisciplinary fashion with input from both the nursing and the medical fields. N.A.A.C.O.G. recommended that national standards be formulated. N.A.A.C.O.G. also suggested that for midwives the certification process should consist of the following three phases: 1) the development of standards 2) the identification of qualifications for eligibility for certification and 3) the development of a mechanism for determining competence.

Legislative reform, such as the deletion of midwifery practice from the Manitoba Medical Act, or the establishment of new legislation providing for a self-governing midwifery profession, was raised. M.A.R.N. indicated that the Registered Nurses Act allows for a broader role for nurses in perinatal care.

The Manitoba Association of Women and the Law pointed to the need for amendments to the Health Insurance Act to allow midwifery services to be covered by the plan. This group also referred to changes to legislation relating to hospitals that would make it possible for midwives to secure hospital admitting privileges.

Respondents unanimously agreed that there is a need for high quality midwifery education and training. Physician and nursing organizations support midwifery training within the context of nursing education, most likely at a university graduate level. These groups noted the necessity of recruiting highly qualified faculty. Since Manitoba is limited in perinatal practice and research, they suggested that the cost of establishing perinatal educational programs

may be prohibitive. Nevertheless, they acknowledged the need to develop Canadian midwifery programs.

Other organizations such as the Manitoba Association of Childbirth and Family Education, the Women's Health Clinic and the Manitoba Organized Midwifery Sisterhood argued for a post secondary educational program which would allow direct entry without previous professional status as a nurse. It is the view of these organizations that this kind of a program would accommodate students with previous education and/or experience in midwifery.

All respondents identified a number of potential difficulties regarding the implementation of midwifery services in Manitoba. These include: opposition from medical professionals who may view the establishment of midwifery as a threat; difficulty in maintaining competence due to competition among professions for patients; public uncertainty regarding the role of midwives and the safety of "non-doctor" care; increased costs of obstetrical care due to the addition of another member to the maternity care team; the escalating costs of malpractice insurance coverage; and the capacity of midwifery training opportunities in Canada.

The potential benefits of implementing midwifery services outnumbered the difficulties. Potential benefits identified include:

- the addition to the maternity care team of an expert practitioner whose skills, training and commitment are focused on the normal aspects of child-bearing;
- increased comprehensiveness and continuity of care for birthing women;
- minimization of the dehumanizing effects of "high tech" hospital care;

- recognition of the autonomy and individuality of each birthing mother;

- encouragement for the active participation of birthing women in health care decision-making;

- provision of personnel for underserviced regions such as northern and rural areas;

- reduced morbidity and mortality rates;

- more appropriate use of technology and anaesthesia;

- reduced health care costs; and

- increased patient satisfaction.

Overall, respondents emphasized the ultimate goal of providing better health care alternatives to childbearing families. Although groups may differ in their views regarding implementation strategies for midwifery services, most nevertheless support midwifery as a vital and important addition to the Manitoba health care system.

ENDNOTES

1. Health care provider groups contacted by the Advisory Council included:

   Manitoba Association of Registered Nurses;
   College of Physicians and Surgeons of Manitoba;
   Manitoba Medical Association, Obstetrics and Gynecology Section;
   College of Family Physicians of Canada, Manitoba Chapter;
   School of Nursing, University of Manitoba;
   Nurses Association of the American College of Obstetricians and Gynecologists;
   Department of Obstetrics, Gynecology and Reproductive Sciences, University of Manitoba;
   Division of Community and Northern Medicine, University of Manitoba;
   Manitoba Organized Midwife Sisterhood;
   Midwifery Project Committee, St. Boniface Hospital;
   Medical Services (Manitoba) Department of Health and Welfare Canada; and
   Mount Carmel Clinic

   Health care consumer groups included:

   Manitoba Action Committee on the Status of Women;
   Manitoba Association of Women and the Law;
   Manitoba Women's Institute;
   Manitoba Metis Women's Alliance;
   Northern Options for Women;
   Indigenous Women's Collective;
   Children's Home;
   Manitoba Association for Childbirth and Family Education;
   Parent and Childbirth Educators; and
   Women's Health Clinic (also a provider group)

2. Manitoba Organized Midwife Sisterhood;
   School of Nursing, University of Manitoba;
   Nurses Association of the American College of Obstetricians and Gynecologists;
   Department of Obstetrics, Gynecology and Reproductive Sciences, University of Manitoba;
   Manitoba Association of Registered Nurses;
   College of Family Physicians of Canada, Manitoba Chapter;
   Manitoba Association for Childbirth and Family Education;
   Women's Health Clinic;

Manitoba Association of Women and the Law;
Manitoba Women's Institute;
Division of Community and Northern Medicine, University of Manitoba;
College of Physicians and Surgeons of Manitoba;
Midwifery Project Committee, St. Boniface Hospital; and
Mount Carmel Clinic

3. Manitoba Association of Women and the Law;
Manitoba Association for Childbirth and Family Education; and
Women's Health Clinic

4. Manitoba Association of Registered Nurses;
Nurses Association of the American College of Obstetricians and Gynecologists;
College of Physicians and Surgeons of Manitoba;
Department of Obstetrics, Gynecology and Reproductive Sciences, University of Manitoba; and
School of Nursing, University of Manitoba

5. Manitoba Association for Childbirth and Family Education;
Women's Health Clinic;
Manitoba Association of Women and the Law; and
Manitoba Organized Midwife Sisterhood

6. Manitoba Women's Institute;
Division of Community and Northern Medicine, University of Manitoba;
Mount Carmel Clinic; and
Midwife Project Committee, St. Boniface Hospital

CONSULTATION PROCESS

Midwifery, with its emphasis on the normal aspects of birthing and the participation of women in the birthing process, offers a kind and a continuity of care that is essential to a comprehensive maternity health care system.

It is the view of the Manitoba Advisory Council on the Status of Women that all birthing women must have opportunities to make informed choices from a range of birthing options, which includes midwifery care.

While the incorporation of midwifery into the health care system is a position that has been adopted by the Advisory Council, several questions remain unanswered in relation to the implementation of midwifery and the education and training of midwives. Some of the more important of these have been raised in this discussion paper.

The Advisory Council intends to distribute this paper to individuals and organizations across the province and to use it to frame the basis of consultations with small groups of Manitoba women in urban, rural and northern centres. For use by individuals and organizations which may not have an opportunity to participate in Council's consultations, we have prepared a series of questions for discussion which are contained in the appendix to this paper.

If you and/or your organization are interested, please feel free to prepare a written response to these questions and forward it to us. Your views are welcome whether they be as informal as a few lines jotted on a piece of paper or as formal as a resolution brought forward by your organization. Please be assured that your views will be taken into serious consideration by Council in making formal recommendations to the Manitoba Government on the incorporation of midwifery into the health care system.

APPENDIX:
QUESTIONS FOR DISCUSSION

QUESTIONS FOR DISCUSSION

1. Do you support the legalization of midwifery and its incorporation into Manitoba's health care system? Why/Why not?

2. What do you see as the advantages and/or disadvantages of moving towards a community-based maternity care system which includes the services of midwives?

3. Should midwifery be incorporated into the Registered Nurses Act and hence, be licensed and governed by the Manitoba Association of Registered Nurses?

4. Should midwifery be governed by an autonomous, self-regulating professional body responsible for developing standards of practice, and for licensing and disciplining its members?

5. What should be the legally prescribed nature of the relationship between midwives and physicians? Should it be collegial, consultative or should midwives be supervised by, and responsible to, physicians?

6. What type of educational route should be required for an individual to gain professional status as a midwife? Should educational programs in midwifery be direct entry or should they be offered only as an advanced specialty of nursing?

7. Should previous experience and/or training in midwifery practice be recognized in educational programs? Should provision be made for grandmothering clauses, advanced standing admissions, reciprocity agreements with other provinces and countries and so on?

8. How might educational programs in midwifery be made accessible to all women including northern, rural and immigrant women?